IDAPA 17 - INDUSTRIAL COMMISSION

17.02.08 - MISCELLANEOUS PROVISIONS

DOCKET NO. 17-0208-0602

NOTICE OF RULEMAKING - TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 1, 2006.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, and 72-723, and Section 72-803 of the Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule: Incorporates recommendations submitted by an industry work group, including representatives from the Idaho Medical Association, using the Resource-Based Relative Value Scale (RBRVS) and the Relative Value Unit (RVU) assigned for all medical services with a Physicians' Current Procedural Terminology (CPT) code. A Conversion Factor for various categories of CPT coded services is proposed. Unnecessary language is proposed to be deleted from the rule.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This temporary rule is needed to comply with the statutory directive to have conversion factors set prior to the effective date of April 1, 2006.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Thomas E. Limbaugh, Commissioner, 208-334-6000.

DATED this 21st day of February, 2006.

Thomas E. Limbaugh, Commissioner
Idaho Industrial Commission
317 Main Street
P.O. Box 83720
Boise, ID 83720-0041

THE FOLLOWING IS THE TEXT OF DOCKET NO. 17-0208-0602

031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES UNDER THE IDAHO WORKERS' COMPENSATION LAW.

Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission (hereinafter "the Commission") hereby ~~*substitutes*~~ adopts the following ~~*for the January 28, 1975 amendment to the "Rules and Regulations Governing Charges for Medical Services Provided under the Idaho Workers' Compensation Law," dated May 2, 1973*~~ rule for determining acceptable charges for medical services provided under the Idaho Workers' Compensation Law: ~~*(6-1-92)*~~(4-1-06)T

01. ~~***Acceptable Charges Under the Idaho Workers' Compensation Law.*** *Payors shall pay a Provider's*~~

~~*reasonable charge for Medical Services furnished to industrially injured patients.* *(6-1-92)*~~

0~~2~~1. Definitions. Words and terms used in this rule are defined in the subsections which follow. (6-1-92)

a. "Provider" means any person, firm, corporation, partnership, association, agency, institution or other legal entity providing any kind of medical service~~s~~ related to the treatment of an industrially injured patient which are compensable under Idaho's Workers' Compensation Law. ~~*(6-1-92)*~~(4-1-06)T

b. "Payor" means the legal entity responsible for paying medical benefits under Idaho's Workers' Compensation Law. (6-1-92)

c. "Medical Service~~s~~" means medical, surgical, dental or other attendance or treatment, nurse and hospital service, medicine~~s~~, apparatus, appliance~~s~~, prostheses, and related service~~s~~, facilit~~*ies*~~y, equipment and suppl~~*ies*~~y. ~~*(7-1-95)*~~(4-1-06)T

d. "Reasonable," ~~*except as provided in Subsections 031.02.g. and 031.02.h.,*~~ means a charge does not exceed the Provider's "usual" charge and does not exceed the "customary" charge, as defined below. ~~*(7-1-95)*~~(4-1-06)T

e. "Usual" means the most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients. ~~*(7-1-95)*~~(4-1-06)T

f. "Customary" means a charge which shall have an upper limit no higher than the 90th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given medical service. ~~*(7-1-95)*~~(4-1-06)T

~~***g.*** *Provided, however, that for medical services which are not represented by CPT codes, reasonableness of charges shall be determined based on all relevant evidence available, including industry standards, invoices and catalog prices.* *(7-1-95)*~~

~~***h.*** *Provided, further, that where a Medical Service is one that is exceptional, unusual, variable, rarely provided, or so new that a determination cannot be made as to whether the charge for the Medical Service meets the criteria of Subsections 031.02.d. through 031.02.f. above, or where the Industrial Commission staff determines that its database is statistically unreliable, reasonableness of charges shall be determined based on all relevant evidence available.* *(7-1-95)*~~

02. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services calculated in accordance with this rule or as billed by the provider, whichever is less. (4-1-06)T

a. Adoption of Standard. The Commission hereby adopts the Resource-Based Relative Value Scale (RBRVS), published by the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services, as amended, as the standard to be used for determining the acceptable charge for medical services provided under the Idaho Workers' Compensation Law. (4-1-06)T

b. Conversion Factors. The following conversion factors shall be applied to the Relative Value Unit (RVU) found in the latest RBRVS, as amended, that was published before December 31 of the previous calendar year for a medical service identified by a code assigned to that service in the latest edition of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, as amended:

CPT CODE:	DESCRIPTION:	CONVERSION FACTOR:
00000 - 09999	Anesthesia	$ 58.19
10000 - 69999	Surgery:	

CPT CODE:	DESCRIPTION:	CONVERSION FACTOR:
10000 - 19999	Integumentary System	$ 67.00
20000 - 21800	Musculoskeletal System	$ 88.00
22100 - 22999	Spine	$ 135.00
23000 - 23999	Shoulder	$ 96.00
24000 - 24999	Upper arm and Elbow	$ 105.00
25000 - 26989	Forearm and Hand	$ 88.00
27000 - 27299	Pelvis and Hip	$ 135.00
27300 - 27899	Leg	$ 105.00
28000 - 28999	Foot and Toes	$ 88.00
29000 - 29750	Casts and Strapping	$ 60.00
29800 - 29999	Endoscopy and Arthroscopy	$ 130.00
30000 - 37799	Respiratory and Cardiovascular	$ 88.00
40000 - 49999	Digestive System	$ 93.00
50000 - 59999	Urinary System	$ 88.00
60000 - 60999	Endocrine System	$ 88.00
61000 - 61999	Skull, Meninges and Brain	$ 125.00
62000 - 62258	Repair, Neuroendoscopy and Shunts	$ 135.00
62263 - 62368	Spine and Spinal Cord	$ 88.00
63000 - 63999	Spine and Spinal Cord	$ 155.00
64400 - 64530	Nerves and Nervous System	$ 88.00
64550 - 64999	Nerves and Nervous System	$ 125.00
65000 - 69990	Eye and Ear	$ 88.00
70000 - 79999	Radiology	$ 85.00
80000 - 89999	Pathology and Laboratory	No RVUs
90465 - 90749	Immunization	$ 35.00
90780 - 90784	Infusions and Injections	$ 59.00
90788 - 90799	Injections	$ 35.00
90801 - 92998	Psychiatry and Medicine	$ 59.00
93000 - 93999	Cardiography and Studies	$ 70.00
94000 - 94750	Pulmonary	$ 70.00
94760 - 94762	Pulse Oximetry	$ 40.00
94770 - 95999	Allergies; Testing	$ 70.00
96000 - 96999	Assessments and Special Procedures	$ 59.00
97000 - 97799	Physical Medicine and Rehabilitation	$ 45.00

CPT CODE:	DESCRIPTION:	CONVERSION FACTOR:
97802 - 98999	Acupuncture, Osteopathy, Chiropractic	$ 43.00
99000 - 99499	Miscellaneous Services	$ 65.00

(4-1-06)T

c. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the Anesthesia Base Units assigned to that CPT Code by the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services as of December 31 of the previous calendar year, plus the allowable time units reported for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time units will not be used for CPT Codes 01995 and 01996. (4-1-06)T

d. Adjustment of Conversion Factors. The conversion factors set out in this rule shall be adjusted prior to the beginning of each state fiscal year (FY), starting with FY 2008. The Commission shall determine the adjustment, which shall equal the percent change in the all item consumer price index for the west urban area, as published by the U.S. Department of Labor, for the twelve-month (12) month period ending with December of the prior year. (4-1-06)T

e. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a CPT code, a currently assigned RVU or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant factors, as determined by the Commission. Where a service with a CPT Code, RVU and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Subsection 031.02.b., determine the reasonable charge for that service, based on all relevant factors in accordance with the procedures set out in Subsection 032.11. (4-1-06)T

f. Coding. The Commission will generally follow the coding guidelines published by the Centers for Medicare & Medicaid Services and by the American Medical Association, including the use of modifiers. The Commission will not use place-of-service codes. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows: (4-1-06)T

i. Modifier 50: Additional 50% for bilateral procedure. (4-1-06)T

ii. Modifier 51: 50% of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. (4-1-06)T

iii. Modifier 80: 25% of coded procedure. (4-1-06)T

iv. Modifier 81: 15% of coded procedure. This modifier applies to MD and non-MD assistants. (4-1-06)T

032. BILLING AND PAYMENT REQUIREMENTS FOR MEDICAL SERVICES AND PROCEDURES PRELIMINARY TO DISPUTE RESOLUTION.

01. Authority and Definitions. Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission hereby promulgates this rule augmenting IDAPA 17.02.08.031~~ *(formerly 17.01.03.803.A, which became effective June 1, 1992)*~~. The definitions set forth in IDAPA 17.02.08.031 are incorporated by reference as if fully set forth herein. ~~*(1-1-93)*~~(4-1-06)T

02. Time Periods. None of the periods herein shall begin to run before the Notice of Injury/Claim for Benefits has been filed with the Employer as required by law. (1-1-93)

03. Provider to Furnish Information. A Provider, when submitting a bill to a Payor, shall inform the Payor of the nature and extent of Medical Services furnished and for which the bill is submitted. This information

shall include, but is not limited to, the patient's name, the employer's name, the date the Medical Service was provided, the diagnosis, if any, and the amount of the charge or charges. Failure to submit a bill complying with Subsection 032.03 to the Payor within one hundred twenty (120) days of the date of service will result in the ineligibility of the Provider to utilize the dispute resolution procedures of the Commission set out in Subsection 032.11 for that service. ~~(1-1-93)~~(4-1-06)T

a. CPT and ICD Coding. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the American Medical Association's appropriate Current Procedural Terminology (CPT) coding, including modifiers, for the year in which the service was performed and using current International Classification of Diseases (ICD) diagnostic coding, as well. (7-1-95)

b. Contact Person. The bill shall also contain the name, address and telephone number of the individual the Payor may contact in the event the Payor seeks additional information regarding the Provider's bill. (1-1-93)

c. Report to Accompany Bill. If required by the Payor, the bill shall be accompanied by a written report as defined by IDAPA 17.02.04.322.01.f. Where a bill is not accompanied by such Report, the periods expressed in Subsections 032.04 and 032.06, below, shall not begin to run until the Payor receives the Report. (7-1-95)

04. Prompt Payment. If the Payor acknowledges liability for the claim and does not send a Preliminary Objection to, or Request for Clarification of, any charge, as provided in Subsection 032.06, below, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill. ~~*The Commission will strictly apply all time limits and deadlines established by this rule. However, a reasonable good faith effort to comply with the other provisions of this rule will generally be sufficient to protect a party's rights hereunder.*~~ ~~(1-1-93)~~(4-1-06)T

05. Partial Payment. If the Payor acknowledges liability for the claim and, pursuant to Subsection 032.06 below, sends a Preliminary Objection, a Request for Clarification, or both, as to only part of a Provider's bill, the Payor must pay the charge or charges, or portion thereof, as to which no Preliminary Objection and/or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. ~~*The Commission will strictly apply all time limits and deadlines established by this rule. However, a reasonable good faith effort to comply with the other provisions of this rule will generally be sufficient to protect a party's rights hereunder.*~~ ~~(7-1-95)~~(4-1-06)T

06. Preliminary Objections and Requests for Clarification. (1-1-93)

a. Preliminary Objection. Whenever a Payor objects to all or any part of a Provider's bill on the ground that such bill contains a charge or charges that do not comport with the applicable administrative rule, the Payor shall send a written Preliminary Objection to the Provider within thirty (30) calendar days of the Payor's receipt of the bill explaining the basis for each of the Payor's objections. (1-1-93)

b. Request for Clarification. Where the Payor requires additional information, the Payor shall send a written Request for Clarification to the Provider within thirty (30) calendar days of the Payor's receipt of the bill, and shall specifically describe the information sought. (1-1-93)

c. Provider Contact. Each Preliminary Objection and Request for Clarification shall contain the name, address and phone number of the individual located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. ~~(1-1-93)~~(4-1-06)T

d. Failure of Payor to Object or Request or Provide Contact. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill and/or a Request for Clarification within thirty (30) calendar days of receipt of the bill, or provide an in-state contact in accord with Subsection 032.06.c., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. ~~(1-1-93)~~(4-1-06)T

07. Provider Reply to Preliminary Objection and/or Request for Clarification. (1-1-93)

a. Where a Payor has timely sent a Preliminary Objection, Request for Clarification, or both, the Provider shall send to the Payor a written Reply, if any it has, within thirty (30) calendar days of the Provider's receipt

of each Preliminary Objection and/or Request for Clarification. (1-1-93)

b. Failure of Provider to Reply to Preliminary Objection. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (1-1-93)

c. Failure of Provider to Reply to Request for Clarification. If a Provider fails to timely reply to a Request for Clarification, the period in which the Payor shall pay or issue a Final Objection shall not begin to run until such clarification is received. (1-1-93)

08. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part and/or shall send to the Provider a written Final Objection, if any it has, to all or part of the bill within thirty (30) calendar days of the Payor's receipt of the Reply. (1-1-93)

09. Failure of Payor to Finally Object. Where the Payor does not timely send a Final Objection to any charge or portion thereof to which it continues to have an objection, it shall be precluded from further objecting to such charge as unacceptable. (1-1-93)

10. Investigation of Claim Compensability. Where a Payor is investigating the compensability of a claim as to which a Provider has submitted a bill, the Payor must send a Notice of Investigation of Claim Compensability to the Provider and the Patient within fifteen (15) calendar days of receipt of the Provider's bill. The Payor shall complete its investigation of claim compensability and notify the Commission, the Provider and the Patient of its determination within thirty (30) calendar days of the date the Notice of Investigation of Claim Compensability is sent. Where a Payor does not timely notify the Commission, the Provider and the Patient of its determination, the Payor shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (1-1-93)

a. Single Objection Sufficient. A single objection stating that liability has been denied shall be sufficient for each Provider from whom a bill is received. (1-1-93)

b. Effect of Commission Determination of Claim Compensability. The thirty (30) day period in which the Payor must pay the bill or send a Preliminary Objection and/or Request for Clarification shall recommence running on the date of entry of a final Commission order determining that the claim is compensable. (1-1-93)

c. Effect of Determination of Compensability. If the Payor, absent a Commission determination of claim compensability, concludes that it is liable for a claim, the thirty (30) day period in which the Payor must pay the bill or send a Preliminary Objection and/or Request for Clarification shall begin running on the date the Payor notifies the Commission, Provider and Patient that it accepts liability for the claim. (1-1-93)

11. Dispute Resolution Process. If, after completing the applicable steps set forth above, a Payor and Provider are unable to agree on the appropriate charge for any Medical Service, a Provider which has complied with the applicable requirements of this rule may move the Commission to resolve the dispute as provided in the Judicial Rule Re: Disputes Between Providers and Payors as Referenced in ~~*IDAPA 17.02.08.*~~ Sections 031 and 032 of this rule ~~*(formerly 17.01.03.803.a. and 803.b.)*~~. ~~*(1-1-93)*~~(4-1-06)T

~~***12. Requirements Regarding Disputes Arising Before the Effective Date of This Rule.*** *(1-1-93)~~

~~***a.*** *Written Demand Required. If, prior to January 1, 1993, a Payor notifies or has notified a Provider that it does not intend to fully pay any charge for Medical Services incurred prior to January 1, 1993, the Provider seeking payment for such charge must send a written Demand for Payment to the Payor no later than January 31, 1993. (Note: Should the matter ultimately proceed to the dispute resolution phase set forth in the Judicial Rule, the Commission will resolve the dispute by applying the administrative rule which was in effect at the time the charge was incurred. Hence, if the charge in dispute was incurred prior to June 1, 1992, the Commission will use this dispute resolution process to determine whether the Provider's charge is acceptable pursuant to the provisions of IDAPA 17.01.03.803, then in effect. However, if the charge in dispute was incurred on or after June 1, 1992, the Commission will use this dispute resolution process to determine whether the Provider's charge is acceptable pursuant to the provisions of IDAPA 17.02.08.031, now in effect.)* *(1-1-93)~~

~~***b.*** *All Provisions of this Rule Will Apply. Such a Demand shall substitute for the bill and Report referenced in Subsection 032.03 above, and must contain all the information required by that section. Service of a timely Demand for Payment will bring the other provisions of this rule into operation.* *(1-1-93)*~~

~~***c.*** *Failure of Provider to Make Written Demand. Providers failing to make a written Demand for Payment within thirty (30) calendar days of the effective date of this rule shall be forever barred from invoking the Dispute Resolution Process set forth in the applicable Judicial Rule. Demands and/or billings submitted previously either to the Payor or to the Commission will not suffice.* *(1-1-93)*~~